# Medicaid Information Bulletin

**October 2003**

**Web address:** http://health.utah.gov/medicaid

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## BULLETINS BY TYPE OF SERVICE



**World Wide Web:** http://health.utah.gov/medicaid (Formerly http://www.health.state.ut.us/medicaid)

**Medicaid Information**

- **Salt Lake City area, call 538-6155.**
- **In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.**
- **From other states, call 1-801-538-6155.**

**Requesting a Medicaid publication?**

**Send a Publication Request Form.**

- **by FAX: 1-801-536-0476**
- **by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106**

**03 - 71 Reminder Cross-Over Claims to be Processed by Health Care Financing Beginning October 1, 2003**

October 1, 2003, the Division of Health Care Financing will begin processing the Medicaid portion of Medicare Crossover claims for patients who have both Medicare and Medicaid coverage. When implemented, providers should contact Medicaid Information concerning the Medicaid portion of the Crossover claims, rather than contacting the Medicare Intermediary in Utah (Blue Cross/Blue Shield) as is done now.

**Provider Manuals Modified**
Two sections of the Utah Medicaid Provider Manual are updated to include the new billing address and other information relevant to Crossover claims.

SECTION 1, GENERAL INFORMATION,
Chapter 11 - 6, Medicare/Medicaid Crossover Claims
Chapter 11 - 7, Filing Crossover Claims, page number 41.

There is a link to the current version of SECTION 1 on the Medicaid Provider's web site: http://health.utah.gov/medicaid A vertical line marks where text was changed. A reminder of this change in billing procedures under the section for Crossover claims will be posted on the Medicaid Provider's WHAT'S NEW site: http://health.utah.gov/medicaid/provhtml/what_s_new.html

**Medicare/Medicaid Crossover Claims**
A Crossover Claim is a coordination of benefit claim for a recipient who has both Medicare and Medicaid eligibility. If the provider accepts assignment for Medicare Part A or Part B, the Crossover claim is sent to Medicaid Crossovers automatically from the intermediary. If the provider does not accept assignment, a claim is not sent automatically, and the provider must submit the claim directly to Medicaid Crossovers.

There are two exceptions:
- Inpatient claim, Part B only. After Medicare pays the claim, it is processed as a Medicaid claim with the Medicare payment on the claim. Medicaid then pays the hospital charges.
- Out of plan claims, with the Medicaid Insurance Payment Report Form (IPR) attached.

Payment is reported on the Crossover section of the Medicaid Remittance Statement. The Medicare and Medicaid payment is considered payment in full.

**Filing Medicare/Medicaid Crossover Claims**
Submit claim and a Medicaid Insurance Payment Report Form (IPR) directly to Medicaid Crossovers. The form and instructions are in the General Attachments Section of the Medicaid Provider Manual or on-line at http://health.utah.gov/medicaid/ An IPR must be submitted with the claim regardless of the payment amount.

To ensure prompt processing, the Medicaid provider number must be on the claim. The deadline for filing a Crossover claim is six (6) months from the date of the Medicare payment.
PAPER CLAIMS:

Submit to:

Medicaid Crossovers

P.O. Box 143106

Salt Lake City, Utah 84114-3106

ELECTRONIC CLAIMS:

It is not necessary to submit an EOMB for $0 payment or denials. Complete the other payer payment information, including payer paid amount, patient liability and reason codes.

Submit to:

HT000004-005 Utah Medicaid Crossovers ☐

### 03- 72 Billing Form Change

Medicaid is changing claim formats for the following providers:

| | |
|---|---|
| Ambulatory Surgical Centers | ANSI X12 837 Institutional, or UB92 |
| Freestanding Birthing Centers | ANSI X12 837 Institutional, or UB92 |
| Nursing Homes | ANSI X12 837 Institutional, or TAD (turnaround document) |
| Home Health | Nursing Services: ANSI X12 837 Institutional |
| Medical Supplies: | ANSI X12 837 Professional |
| Pharmacy Services: | POS 5.1 |
| Rural Health Centers | ANSI X12 837 Institutional, or UB92 |
| Federally Qualified Health Centers | ANSI X12 837 Institutional, or UB92 |

For more information and implementation dates, visit the Medicaid HIPAA website at http://www.health.utah.gov/hipaa/medicaid_pcn.htm . ☐

### 03- 73 Procedure Codes with Time Definitions

Many procedure codes contain time frames built into the definition. For billing services that fall between the time frames, Medicaid's policy is to round to the nearest full unit or appropriate procedure code. No partial units may be reported.

Example:

T1002 - RN services, up to 15 minutes
17 minutes = 1 unit
23 minutes = 2 units

90823 - Individual psychotherapy....20-30 min
90826 - Individual psychotherapy .....45-50 min
34 minutes = 90823
42 minutes = 90826

☐

### 03- 74 Billing New/discontinued Procedure Codes

With the implementation of HIPAA, and the requirement to bill standard codes that are in effect on the date of service, Medicaid will no longer have a 3-month grace period for utilizing new/discontinued procedure codes. All codes will be discontinued or added based on the date of implementation set by the standard setting organization, i.e., AMA, ADA, etc. Claims submitted with invalid codes for the date of service will be denied. ☐

### 03- 75 Attention: Mental Health Centers

Effective October 1, 2003, the Utah Medicaid Provider Manual for Mental Health Centers and the Targeted Case Management for the Chronically Mentally Ill, Utah Medicaid Provider Manual have undergone the following revisions:

1. Procedure Codes– In order to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations regarding billing code standardization, these provider manuals have been updated to include changes in procedure codes.

   As of October 1, 2003, Medicaid Y codes will be discontinued. Medicaid Y codes have been replaced with CPT-4

codes whenever possible. When this was not possible, they were replaced with other standardized HCPCS codes. The names of covered services have also been changed to match the names associated with the new service codes.

Providers must use the new procedure codes for dates of service on or after October 1, 2003.

2. The Utah Medicaid Provider Manual for Mental Health Centers has also been updated to:

   a. include a revision on the limitation on techniques referred to as "holding therapy," "rage reduction therapy," or "rebirthing therapy;"

   b. clarify evaluation procedures;

   c. clarify treatment plans and treatment plan reviews;

   d. clarify the "Record" requirements for all services;

   e. clarify the Quality Improvement chapter; and

   f. clarify the Collateral Services chapter.

Mental health centers will find attached a revised SECTION 2 to update their Utah Medicaid Provider Manual for Mental Health Centers. Mental health centers will also find attached page 12 of the Utah Medicaid Provider Manual, Targeted Case Management for the Chronically Mentally Ill Manual showing the new procedure code for this service. A vertical line is placed in the left margin next to the text which has been changed.

Please contact Merrila Erickson at 1-801-538-6501 or e-mail merickson@utah.gov if there are questions. ☐

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**03- 76 Attention: Substance Abuse Providers**

Effective October 1, 2003, the Utah Medicaid Provider Manual, Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse provider manual has undergone the following revisions:

1. Procedure Codes– In order to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations regarding billing code standardization, these provider manuals have been updated to include changes in procedure codes.

   As of October 1, 2003, Medicaid Y codes will be discontinued. Medicaid Y codes have been replaced with CPT-4 codes whenever possible. When this was not possible, they were replaced with other standardized HCPCS codes. The names of covered services have also been changed to match the names associated with the new service codes.

   Providers must use the new procedure codes for dates of service on or after October 1, 2003.

2. The treatment services portion of the manual has also been updated to:

   a. include a revision on the limitation on techniques referred to as "holding therapy," "rage reduction therapy," or "rebirthing therapy;"

   b. clarify evaluation procedures;

   c. clarify treatment plans and treatment plan reviews;

   d. clarify the "Record" requirements for all services; and

   e. clarify the Collateral Services chapter.

Providers will find attached a revised SECTION 2 to update their manual. A vertical line is placed in the left margin next to the text which has been changed.

Please contact Merrila Erickson at 1-801-538-6501 or e-mail merickson@utah.gov if there are questions. ☐

**03- 77 Attention: Licensed Psychologists**

Effective October 1, 2003, the Utah Medicaid Provider Manual-Psychology Services has undergone the following revisions:

1. Procedure Codes– In order to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations regarding billing code standardization, procedure codes have changed. Medicaid Y codes have been discontinued and replaced with CPT-4 codes. The names of covered services have also been changed to match the CPT-4 code terminology.

   Providers must use the new procedure codes for dates of service on or after October 1, 2003.

2. With implementation of CPT-4 codes for this program, prior authorization of services will no longer be required. You may bill services directly to Medicaid if:

   a. Children in state custody– Children in state custody are NOT enrolled in the Prepaid Mental Health Plan (PMHP) for outpatient mental health care. Therefore, if you provide services to a foster care child, you may bill Medicaid directly and Medicaid will pay the claim.

   b. Prepaid Mental Health Plan Enrollees– As per the Utah Medicaid Provider Manual-Psychology Services, there are limited circumstances under which you may be able to provide services to a PMHP enrollee and be paid directly by Medicaid. If you think one of these circumstances applies, yet Medicaid denies your claim, contact Merrila Erickson at Medicaid for review. She can be contacted at 1-801-538-6501 or e-mail merickson@utah.gov.

3. Other manual revisions include:

   a. Chapter 1 - 1, General Policy, of SECTION 2 has also been updated to include another exception to enrollment in the Prepaid Mental Health Plan.

   b. A revision of the limitation on techniques referred to as “holding therapy,” “rage reduction therapy,” or “rebirthing therapy;” and

Providers will find attached a revised SECTION 2 to update their provider manuals. A vertical line is placed in the left margin next to the text which has been changed.

Please contact Merrila Erickson at 1-801-538-6501 or e-mail merickson@utah.gov if there are questions. ☐

**03- 78 Attention: Diagnostic and Rehabilitative Mental Health Services by DHS Contractor Providers**

Effective October 1, 2003, the Utah Medicaid Provider Manual for Diagnostic and Rehabilitative Mental Health Services by DHS Contractors has undergone a major revision that includes changes in the procedure codes in order to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations regarding billing code standardization. Medicaid Y codes have been discontinued and replaced with CPT-4 codes whenever possible. When this was not possible, they were replaced with other standardized HCPCS codes. The names of covered services have also been changed to match the names associated with the new service codes.

Providers must use the new procedure codes for dates of service on or after October 1, 2003.

A copy of SECTION 2 of this provider manual has been sent under separate cover to Medicaid providers enrolled to provide services under this program. The changes in the manual are identified by a vertical line in the left margin next to the text which has been changed. If you are a DHS-contracted provider and do not receive a copy, please contact Medicaid Information.

Please contact Merrila Erickson at 1-801-538-6501 or e-mail merickson@utah.gov if there are questions. ☐

**03- 79 Attention: Targeted Case Management for the Homeless Providers**

Effective October 1, 2003, the Utah Medicaid Provider Manual-Targeted Case Management for the Homeless has been updated to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations regarding billing code standardization. The current Medicaid Y code will be discontinued and replaced with a standardized HCPCS procedure code.

Providers must use the new procedure codes for dates of service on or after October 1, 2003.

Providers will find attached a revised SECTION 2 to update their provider manuals. A vertical line is placed in the left margin next to the text which has been changed.

Please contact Merrila Erickson at 538-6501 if there are questions. ☐

**03- 80 ATTENTION: Methadone Administration Providers**

Effective October 1, 2003, current Medicaid Y codes will be replaced with standardized HCPCs procedure codes in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The current Medicaid Y code for methadone maintenance, Y6080, will be replaced with H0020.

For dates of service on or after October 1, 2003, you must use this new code, H0020. If you have questions, contact Merrila Erickson at 1-801-538-6501 or e-mail merickson@utah.gov. ☐

**03- 81 Y codes will be closed**

**Effective October 1, 2003, the following Y codes will be closed. The listed replacement HCPCS or the CPT code will be reimbursed at the same rate and conditions as the Y code.**

| Ycode | |
|---|---|
| Y4600 | Vaccines for Children (VFC) Injection fee replaced by 90471 and 90472 with SL modifier |
| Y7600 | Anesthesia sedation for imaging replaced by CPT sedation codes 99141or 99142 |
| Y8880 | Dietitian Special HC needs child by Telehealth replaced by S9470 with GT modifier and TF modifier |
| Y9300 | RN Telehealth homecare 15 minutes (1unit) replaced by T1002 with GT modifier |
| Y9301 | RN Telehealth homecare 30 minutes (2units) replaced by T1002 with GT modifier |
| Y9302 | Dietician Counseling Telehealth Homecare replaced by S9470 with GT modifier and TG modifier |
| Y9590 | Nutrition Assessment & Care Plan replaced by 97802 in 15 minute increments (4 units) limited to 4 units or one hour per year |
| Y9595 | Nutritional Therapy replaced by 97803 in 15 minute increments (4 units) limited to four units per date of service |
| Y0944 | Diabetes Self Management Training replaced by S9455 |
| Y9007 | Directly observed TB therapy office replaced by T1502 |
| Y9008 | Outreach TB DOT replaced by H0033 |
| Y0458 | San Juan Home Health Differential—The Modifier TN must be placed on each line of the claim along with the appropriate home health code. ☐ |

**03- 82 Interpretive Services**

The Division of Health Care Financing has contracted with four companies to provide interpretive services to Medicaid, CHIP and PCN clients who have Limited English Proficiency (LEP). These contracts make interpretive services available by phone 24 hours a day, 7 days a week, 365 days a year, without prior appointment. The telephone services cover almost 180 spoken languages. Additionally, the number of interpreters who are available for scheduled, in-office interpretive services, has increased. The contractors have demonstrated a high level of commitment to professional/ethical standards, to cultural sensitivity and to high standards for training and testing of medical terminology, which enables them to provide

a superior level of service for clients.

The contracts cover interpretive services for Medicaid, CHIP, and PCN clients who are not enrolled in a Managed Care Plan (MCP), or for carve out services including dental, pharmacy and chiropractic care. Clients who are members of a MCP must use the interpretive services offered by the MCP, except for the carve out provision described above. Clients who are members of a Prepaid Mental Health Plan (PMHP) should continue to use the interpretive services provided by the Plan. Interpreters will only be provided for services normally covered by the program for which the client is eligible, to include setting up appointments.

Details on how to access these services and the information that is needed for billing purposes can be found on the Medicaid web site: http://health.utah.gov/medicaid/provhtml/interpreter.html. You may also contact the Medicaid Information Line for instructions on obtaining these services. ☐

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### 03- 83 HIPAA Implementation

The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted by Congress to reform the health care insurance market and simplify health care administrative processes. HIPAA is specifically intended to reduce the costs and administrative burdens of health care by making possible the standardized electronic transmission of many transactions that are currently done on paper.

This standard for electronic transactions final rule is aimed at EDI (electronic data interchange). This rule mandates the use of one standard format (ASC X12) be used to bill any payer, whether that be Medicare, Medicaid, or a private insurer.

#### Medicaid Readiness

All HIPAA transactions will be implemented by Utah Medicaid prior to October 16, 2003. Local codes (Y codes) have been cross-walked to national standard codes with implementation dates ranging from July 2003 through October 2003 (see notification in the Medicaid Information Bulletins).

Visit Medicaid's HIPAA website at http://health.utah.gov/hipaa/medicaid_pcn.htm for further information/updates.

Electronic options currently maintained by Medicaid, which are not HIPAA compliant, will be discontinued once providers are able to transmit in the ANSI X12 formats. These programs include Medicaid On-line, the Bulletin Board and diskette submission of claims.

#### EDI Software

Two software packages have been approved for electronic submission of claims:

UHINT (Utah Health Information Network Transaction) – A new baseline translator product with the ability to file CMS-1500 claims, UB92 claims, dental claims and other HIPAA transactions. UHINT utilizes an Internet-based solution for transmission of transactions. For more information, visit the UHIN website at http://www.uhin.com/new_products.htm.

PROCLAIM – The Proclaim/Acclaim software, which was two different packages, have been combined into one software package which will continue to be called Proclaim. This software meets all requirements for submission of professional, institutional and dental claims and other HIPAA transactions. Proclaim is a dial-up method of data communications operating in a Windows environment. For more information, call the switch help line at (801)333-2900.

Other software is available for transmission of electronic transactions. Medicaid requires the software meet all file and data specifications contained in the ANSI x12 implementation standards.

#### Provider Electronic Data Interchange (EDI) Enrollment

Whether you are a current sender of EDI transactions to Utah Medicaid or wish to start sending transactions, you will need to complete the following steps:

**Step 1:** Complete the Electronic Commerce Agreement with the Utah Health Information Network and obtain a Trading Partner Number (TPN). (UHIN is a not-for-profit organization that allows its members to send and receive the new HIPAA versions of claims and remittances, in addition to all the other HIPAA transactions, reducing the cost of administrative health care through electronic transactions, electronic transaction standards, and education). You will need to obtain the UHIN

Electronic Commerce Agreement from http://www.uhin.com/.

**Step 2:** Complete the Utah Medicaid EDI Enrollment Form. The form is available at http://health.utah.gov/hipaa/medicaid_pcn.htm.
All Trading Partners who are individual Providers or Provider Groups have responsibilities to adequately test all business rules appropriate to their types and specialties. If using a third-party vendor (clearinghouse), it is the obligation of the Trading Partner to ensure that said vendor has adequately tested all business rules appropriate to each and every provider type and specialty.

Once the completed Provider enrollment form has been received by Utah Medicaid, the Provider will be enrolled and a copy of the EDI form will be emailed to the EDI Contact as indicated on the EDI Enrollment Form. Once notification of approval is received from Utah Medicaid, you may begin sending EDI transactions. This process should take approximately 5 business days from the date of receipt.

Our sincere effort is to avoid any unnecessary delays and to expedite your request as soon as possible. To avoid delay in processing, please do not contact our office before 5 business days for enrollment status. It is very important that you complete and return the enrollment form as described above. Incomplete enrollment forms cannot be processed and will be returned to the submitter.

If you have any questions, please contact the Operation, Support and Development Unit at 801-538-6155 or 1-800-662-9651, options 3 and 5. ☐

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### 03- 84 Home Health Services

Clarification is provided in response to questions and issues which have recently been raised in the home health program as a result of the mandatory coding changes and program review. All Home Health Services still require prior authorization.

Speech and physical therapy services are again available as of July 1, 2003, for any patient meeting the criteria. Services must be provided in the most appropriate, cost-effective place of service. The home setting cannot be chosen for convenience, especially if the individual is otherwise able to leave the home for other outpatient services, or to attend school. Inconvenience of scheduling for the therapist is not a valid reason to schedule services in the home.

Medicaid provides enhancements to the home health reimbursement rate when travel distances to provide services are extensive. The enhancement is available only in rural counties where round trip travel distances from the care giver's base of operations are in excess of 50 miles. Effective October 1, 2003, use the **TN** modifier with the applicable approved service code listed in Chapter 6 of the Utah Medicaid Provider Manual for Home Health Services. The home health fee schedule will be multiplied by 1.75 to calculate the payment rate for applicable service codes. Use of the 22 modifier will be discontinued October 1, 2003. ☐

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### 03- 85 ICD 9.CM Codes Updated

The new edition of ICD.9.CM diagnosis and procedure codes has been reviewed. A number of codes are being removed from the manual and are now invalid codes. The new diagnosis codes (Volume 1) will be available for coding claims for service provided in the appropriate Medicaid plan, effective October 1, 2003. All new numeric codes will be covered under the Traditional and Non-traditional Medicaid Plans. The following alpha-numeric codes will be non-covered.
V25.03, V43.22, V45.85, V53.90, V53.91, V53.99. V58.63 through V58.65, V65.11, V65.19, V65.46, E928.4 and E928.5

There are ten new procedure codes (Volume 3). Seven of the new codes will be covered. The three following codes will be non-covered. 37.52, 37.53, and 37.54.

As part of this update, the table titled Utah Medicaid Table of Authorized Emergency Diagnoses has been updated for emergency department services not requiring a copay. A copy of the list is attached.

**Co-Insurance Exemptions for Inpatient Hospital Services**

Diagnoses exempt from Inpatient coinsurance have been identified in the attached table titled Utah Medicaid Table of Authorized Emergency Inpatient Diagnoses ☐

### 03- 86 Pharmacy Point-Of-Sale Software

Effective October 17, 2003, only claims submitted in NCPDP 5.1 will be accepted. Providers may begin submitting the 5.1 version as of July 1, 2003.

**Pharmacy Date of Birth Requirements**

Effective July 1, 2003, pharmacies must submit claims with the complete name and date of birth from the Medicaid card. Claims will be denied if the name and date of birth do not match the date on the Medicaid identification card. Newborns must also be submitted with the information from the card.

Providers may contact the Medicaid Hotline for assistance. Recipients must contact their eligibility workers to correct the information on their cards.

**Drug Returns in Nursing Homes Indicators**

Pharmacies that are using the new NCPDP 5.1 software may identify claims and reversals that are related to the Drug Return program. Identified claims will expedite the review process required for the program. In the result of service field, enter '3C', discontinued drug, for reversal transactions and '1F', filled with different quantity, for rebilled claim transactions.

**Prenatal Indicator Available**

Prenatal vitamins are covered only for pregnant women. Prenatal vitamins are not covered post-delivery.

Pharmacies that are using the new NCPDP 5.1 software must indicate that the recipient is pregnant by using the pregnancy indicator, value '2'.

Effective October 17, 2003, a claim for prenatal vitamins will not be covered unless the pharmacy indicates that the client is pregnant. ☐

### 03- 87 Compounded Prescriptions

Effective October 17, 2003, all pharmacies will be required to submit compounds using the NCPDP 5.1 software, compound segment. Each ingredient covered by Medicaid must be billed with an NDC number and the appropriate quantity, from one tablet to multiple grams of ointment.

Include your usual dispensing fee with each ingredient submitted. Medicaid will reimburse up to three dispensing fees for covered medications. Single ingredient compounds with noncovered diluents or bases will receive one fee despite the difficulty of some compounded entities. Each Medicaid-covered ingredient will be charged a co-payment when appropriate.

Compounded prescription claims with non-covered medications must be submitted with the clarification code 8 to override the non-covered medication and pay the covered medications. Otherwise, the prescription will be denied. ☐

### 03- 88 Prior Approvals

Effective July 1, 2003, Medicaid is accepting prior approval requests electronically for the pharmacy program utilizing the NCPDP 5.1 transactions.

Medicaid will make every effort to transition existing prior approvals with local "Y" codes to the new procedure codes without changing the prior approval number. Providers may bill with the new procedure codes after the local code has been discontinued without obtaining a new prior approval. ☐

### 03- 89 Correction – Abortion Criteria

The Criteria for Medical and Surgical Procedures List, page 11, item #17 (Abortion) has a typographical error which needs to be corrected. Sub item II (A) states that "Pregnancy must be less than 24 weeks gestation" to provide an abortion for rape or incest. That number needs to be changed to 20 weeks. The corrected page 11 is included to update your provider manual. ☐

### 03- 90 Podiatry

Effective October 1, 2003, the following additional codes are open to Traditional and Non-Traditional Medicaid clients:

| | |
|---|---|
| 11422 | EXC,BENIG LES,SCLP,NK,HNDS,FEET,GENIT;1.1 TO 2.0CM |
| 11730 | AVULSION NAIL PLATE, SINGLE, SIMPLE |
| 11750 | EXC NAIL & MATRIX, PARTIAL OR COMPLETE |
| 27814 | OPN TRMNT BIMALLEOLAR ANKLE FX,W W/O IN/EXTERN FIX |
| 28002 | INCISION/DRAIN,W W/O TEND SHEATH,FOOT;SNGL BURSAL |
| 28005 | FOOT INCISION,DEEP/W OPENING BONE CORTE |
| 28080 | EXCISION, INTERDIGITAL NEUROMA, SINGLE, EACH |
| 28090 | EXC LESION TENDON SHEATH, CAPSULE, FOOT |
| 28110 | PART EXC 5TH METATARSAL |
| 28119 | OSTECTOMY,CALCANEUS;FOR SPUR,W W/O PLANTAR FASCIAL |
| 28122 | PARTIAL EXCISION BONE; TARSAL OR METATARSAL BONE |
| 28192 | REMOVAL OF FOREIGN BODY, FOOT; DEEP |
| 28270 | CAPSULOT;METATARSOPH JOINT W W/O TENORRHAPHY,SING |
| 28285 | HAMMERTOE OPERATION ONE TOE(EG FUSION,FILLET,PHAL) |
| 28296 | CORRECTION,HALLUX VALGUS;W METATARSAL OSTEOTOMY |
| 28308 | OSTEOTOMY OS CALCIS, OTH METATARSLS, SN |
| 28470 | CLOSED TRMNT METATARSAL FRACTURE;W/O MANIPULAT,EA |
| 28820 | AMPUTATION TOE, METATARSOPHALANGEAL JNT |

Effective October 1, 2003, code Y8025, Surgical Supply kit, is discontinued with no replacement. ☐

### 03- 91 Atypical Antipsychotics

All atypical antipsychotics require a select diagnosis using the ICD.9 format. Covered diagnoses are determined by the three following age groups: ages 0 through 6; ages 7 through19; ages >19. Attachments to the Drug Criteria List show covered ICD.9 codes for each age group respectively. It is the physician's responsibility to write the correct ICD.9 code on each prescription for an atypical antipsychotic. The pharmacist must enter that ICD.9 code into the appropriate diagnoses field when processing a claim. Effective 10/1/03 ☐

### 03- 92 Dental Claims: Current Ada Form Formats Required (1999, 2002 Versions) for Paper Billing

Effective 10/1/2003, Medicaid will accept the most current dental forms, ADA versions 1999 and 2002, discontinuing the 1994 version. Requiring current ADA form formats facilitates the entry of data into the computer and increases efficiency and cost effectiveness of the claims adjudication process. Medicaid supports electronic billing of all claim formats. ☐

### 03- 93 Dental - Electronic Billing Information

Medicaid accepts dental claims electronically in the ANSI X12N 837 format, version 4010. All other means of electronic submission will be discontinued, i.e., Medicaid Bulletin Board, diskette, etc.

Electronic submission of claims has great benefits.

- Keying errors are decreased due to provider performing direct data entry.
- Provider notified of claims acceptance.
- Claims received electronically by noon on Friday are processed each weekend, improving turn around time for payment.

Medicaid supports the use of all electronic transactions including eligibility inquiry and claims status.

Providers interested in electronic submission of claims or other electronic services must submit through the Utah Health Information Network (UHIN). Either you or your vendor must contact UHIN for enrollment. A trading partner number will be assigned. Visit the UHIN website at www.uhin.com. Software options can also be obtained from UHIN.

After enrollment with UHIN, an EDI enrollment form must be submitted to Medicaid. The form is available at http://health.utah.gov/hipaa/medicaid_pcn.htm

For questions or more information, contact the OS&D unit at 801-538-6155 or 800-662-9651, option 3 then 5. ☐

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**03- 94 Dental**

As of October 1, 2003, code D1550, recementation of space maintainer, is open and placed in the dental manual.

Discontinued codes:
Y1800, IV anesthesia by nurse anesthetist.

Discontinued codes with replacement:
Y1899, Facility charges for ambulatory surgical facility, is replaced with 21299, Unlisted craniofacial and maxillofacial procedure. ☐

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**03- 95 Medical Supplies**

Discontinued PKU nutrition codes:
Y9216 Phenyl aid drink mix
Y9224 Lofenalac
Y9223 Phenyl-Free Powder
Y9230 MSUD Diet Powder
Y9237 Produc 80056
Y9107 PKU-1
Y9231 PKU-2
Y9232 PKU-3
Y9222 XP Maxamaid Orange or unflavored
Y9235 XP Analog
Y9216 Periflex flavored and unflavored
Y9234 XP Maximum Orange and unflavored
Y9212 Phlexy-10 Bars
Y9211 Phlexy-10 capsules
Y9213 Phlexy-10 Drink Mix
Y9226 Amino Acid Blend, non MTE
Y9241 Drink Mix jars: vanilla, orange, strawberry,
Y9242 Amino Acid Bar, Crispy, Smooth
Y9110 Ketonex-1
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Y9101 I-valex-1
Y9105 I-Valex-2
Y9103 Cyclinex-1
Y9104 Cyclinex-2
Y9108 Pro-Phree
Y9250 Low Protein Modified Food Products
Y9218 Thioctic caps alpha lipoic acid
Y9217 Tyr 2, 500 Grams
Y9215 Tyros 2, 454 grams, can
Y9236 Periflex, 454 grams, for PKU
Y9243 Complete amino acid module 200 grams

**PKU nutrition products must now be billed with NDC codes and are no longer payable to medical suppliers.**

**Closed codes:**
A6257, Transparent film, 16 sq inches or less
K0552, Supplies, external infusion pump; syringe, cartridge, sterile, ea
Z6006, IV set, includes tubing, needle, antiseptic, and gloves
Y0676, Motorized wheel chair, design, fitting, and assembly fee for sip-n-puff
Y0354, Arm brace molded
L1000, Cervical-thoracic-lumbar-sacral orthosis (CTLSO) (Milwaukee), inclusive of furnishing initial orthosis, including model
Y6000, Air fluidation bed, microspheres
Y6001, Water fluidation bed
Y0662, Design and fitting fee, pediatric wheelchair
Y0665, Design and fitting fee, adult wheelchair
Y6133, Gel positioning cushion system with attachments
Y6144, Roho cushion, multi-chambered, air pocket
Y0670, Pre wheelchair assessment level I pt./ot adult

**Discontinued codes with replacement codes:**
Y6050RR, Oxygen concentrator is replaced by
E1390, Oxygen concentrator,
Y6605RR, is discontinued with no replacement
Y6610RR, is replaced by
E1390, Oxygen concentrator, plus 4 backup e-tanks billed with a TW modifier.
Oxygen concentrators are only available in state through Peterson's Medical Supply, of Provo, Utah. Concentrator services outside the state boundary must obtain a prior from Medicaid directly and then may bill these codes monthly.

Y0499, Infusion pump, CADD or similar is replaced by E0781, ambulatory infusion pump, single or multichannel.
Y0498, CADD or similar pump bags/cassettes is replaced by A4222, Supplies for external drug infusion pump, per cassette or bag.

**Added codes:**
E1235 Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236 Wheelchair, pediatric size, folding, adjustable, with seating system
E1237 Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238 Wheelchair, pediatric size, folding, adjustable, without seating system
(These codes are complete wheelchairs with all necessary attachments and may be billed without a prior authorization number.)

L0174, Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension
L0454, TLSO flexible, provides truck support, extends from sacrococcygeal junction to above T-9 vertebra
L0460, TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells
L0472, TLSO, triplanar control, hyperextension, rigid anterior and lateral frame
L0484, TLSO, triplanar control, two piece rigic plastic shell without interface liner, custom fabricated
L0486, TLSO, triplanar control, two piece rigid plastic shell with interface liner, custom fabricated.
L1060, Addition of CTLSO or scoliosis orthosis, thoracic pad
L1210, Addition to TLSO, (low profile), lateral thoracic extension
L1240, Addition to TLSO, (low profile), lumbar derotation pad
L1300, Other, scoliosis procedure, body jacket molded to patient model

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### 03- 96 Physical and Occupational Therapy

The HIPAA requirements necessitate the changing of the independent physical and occupational therapy, and the physical/occupational therapy in rehabilitation center coding for Medicaid. This changes the programs slightly. All services performed after September 30, 2003, independent physical therapy and PT in rehabilitation centers, will bill using code Q0086. Independent occupational therapy and OT in rehabilitation centers will bill using the Q0086 code with a GO modifier. Each provider will be paid at the same rate per visit, and only one visit allowed per day. The first ten visits, which includes the evaluation, do not require a prior authorization. All services beyond the first 10 visits need to be prior authorized. The criteria for prior authorization remains unchanged.

For all PT/OT services performed after September 30th, hospital rehabilitation units will discontinue billing using Revenue Codes and should convert to the Q0086 and GO modifier coding.

Beginning October 1, 2003, the following codes are replaced with code Q0086:

**PT/OT Rehabilitation centers** (if billing for OT, include a GO modifier)
Y5304, PT/OT evaluation
Y5305, PT/OT first 10 visits
Y5306, PT/OT treatment beyond 10 visits
**Independent PT**
Y0010, PT evaluation
Y9999, PT first 10 visits
Y0011, PT treatment beyond 10 visits

Beginning October 1, 2003, the following codes are replaced with code Q0086 with a GO modifier.

**Independent OT**
Y5300, OT evaluation, age 20 and younger
Y5301, OT treatment, age 20 and younger
Y5302, OT evaluation, age 21 and older
Y5303, OT treatment, age 21 and older ☐

### 03- 97 Speech

Opened code
V5336, Repair/modification of augmentative communication device. Requires prior authorization and is manually priced.
☐

### 03- 98 CPT Code Changes

**HCPCS Code Discontinued**
G0001 venipuncture

**CPT Codes Covered**
01991 Anesthesia Nerve Blocks & Injection; other than prone Limited to age 20 and under
01992 Anesthesia Nerve Blocks & injection; pron position Limited to age 20 and under
36415 collection of blood by venipuncture
51701 Insertion of non-indwelling bladder catheter
51702 Insert temporary indwelling bladder catheter
53850 Destruction of prostate tissue; microwave thermotherapy (prior removed)
53852 Destruction of prostate tissue; radiofrequency thermotherapy (prior removed)

**CPT Codes Requiring Prior Authorization**
The CPT codes listed below are covered only with prior authorization, either written or telephone as indicated. Criteria are stated on the list dated October 2003.
Written Prior Approval Required for Codes Listed below
21195 Reconstruction mandibular rami w/o internal ridge fixation. . . . .Criteria 5B
21196 Reconstruction mandibular rami with internal ridge fixation . . . .Criteria 5B
61885 Incision/subcutaneous cranial neurostimulator receiver generator . . . . . criteria #32A

**Note:** Code 64590 is appropriately used with sacral neurostimulator placement (64581). Effective with the 2000 CPT manual, use of code 64590 with vagal neurostimulator 64573 placement was discontinued. Typographical errors have been corrected in the Hospital Medical Surgical Procedure List.

**Coding issue discrepancy noted in the April 2003 MIB**
The covered MRI code procedures 72141 through 72158 were discussed as requiring written prior approval under criteria 40B and as requiring documentation with the claim. The covered MRI procedure codes 72141 through 72158 require written prior approval under criteria 40B. This issue was described in the April Nontraditional Medicaid MIB, but left off the traditional Medicaid bulletin. This prior approval is not required for children 20 years of age of younger.

**CPT Code Requiring Documentation with Claim**
Benign or premalignant skin lesion(s) removal (criteria #34) documentation must include sufficient information to support the need for removal. The **number, size, color, shape, and character** of the lesion(s) must be described in the medical record. Pathology reports must also be included with the documentation of review. Insufficient information will result in denial of the claim.

**Editing Notice:**
As per the Medicaid physician Manual, page 9, the supply code A4550 may be warranted on under unusual circumstances when an extensive procedure requires additional surgical supply more than usual. Due to excessive use of this code, an edit will be turned on October 1, 2003, which will post an incidental edit when the procedure billed would not typically require additional surgical supplies. ☐

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**03- 99 New Criteria or Changes to Existing Criteria**

**Criteria #5B: Mandibular Reconstruction**
May approve if there is medical record documentation of:
A. Child with a congenital anomalie creating malocculsion or dentofacial malformation.
B. Fracture of mandible requiring internal fixation or open repair.

**Criteria #32 A: Vagal Neurostimulator**
F. the word neurosurgeon is replaced with surgeon.

**Criteria #35B: Ophthalmic Biometry**
Ophthalmic biometry by ultrasound echography A-scan is used to measure the axial length of the eye to determine the size and power of an intraocular lense implant. An A-scan with amplitude quantification is used to uncover defects such as retinal detachments or tumor when the cataract is too opaque for visualization. The intraocular lens calculation (IOL) is completed only for the eye in which an intraocular lense implant (IOL) is planned. This measurement is useful for calculation of the power for an intraocular lens implant. Optical coherence biometry is a new diagnostic method using partial coherence interferometry to determine axial length, corneal curvature, anterior chamber depth, and intraocular lens calculation. All measurements are stored in a computer, and transferred automatically to the IOL calculation program. The biometry by partial coherence interferometry requires approximately one minute to perform and is less invasive than the standard A-scan echography. Both procedures are similar in sensitivity and specificity. A-scans are often required for mature cataracts which tend to be dense and opaque.

**Coverage:**
1. Diagnosis and medical record documentation must clearly indicate the ophthalmic biometry by A-scan or partial coherence interferometry is medical necessity for evaluation prior to cataract surgery.
2. Diagnosis and medical record documentation of medical necessity for A-scan for use in addition to cataract surgery may include:

- to visualize the posterior chamber in cases where there is a dense cataract or an anterior chamber hemorrhage.
- to clarify the diagnosis and prognosis of a clinical condition such as vitreous hemorrhage or detached retina.
- to assess and follow a mass or tissue density.

Limitations:
1. Biometry by ultrasound 76516 and 76519 are subject to correct coding initiative edits. If both studies (76511 or 76516 and 76519) are reported, the charges are combined and processed under code 76519. The global service for code 76519 includes a bilateral technical component and unilateral professional component. When the procedure is completed on the second eye, only the professional component should be billed.
2. Biometry is indicated just prior to cataract surgery. **One biometry service for each eye is covered for a 12-month period.**

3. It is not considered medically reasonable or necessary to perform both an A-scan and optical coherence biometry (OCB). If biometry by partial coherence interferometry (92136) and an A-scan (76516, 76519) is completed, a mutually exclusive edit per the correct coding initiative will post. The procedure A-scan procedure (76516 or 76519) will be paid, and the code 92136 will be denied.

**Criteria #39: Ultrasound in Pregnancy**

**Coverage:**
1. All obstetrical ultrasounds must be completed through a perinatologist and/or a trained ultrasound certified physician, nurse practitioner, or doctor of osteopathy. The ultrasound must be read by a physician or osteopath.
2. One routine office ultrasound will be covered without prior authorization for all pregnant women at about 18 weeks of gestation or at late prenatal care (18th week through intrapartum). The screening ultrasound should be submitted with the addition of the diagnosis code V22.0, V22.1, or V23.3.
3. There is one exception to the stipulation one ultrasound is permitted without prior authorization. In approximately 20% of patients, bleeding or pain may occur prior to 14 weeks gestation. Appropriate indications for ultrasound in the first trimeter include ectopic pregnancy, spontaneous abortion (threatened, incomplete, missed), molar pregnancy, first trimester bleeding, and intrauterine device. This patient is also allowed the ultrasound at about 18 week gestation without prior authorization.
4. All outlier obstetrical ultrasound or uncovered medically indicated codes submitted for reimbursement need prior approval or retro-emergency physician review.
   - Requests for a repeat ultrasound in cases involving maternal risk factors such as diabetes or hypertension require submission of documentation for medical review.
   - Placenta previa found at the 18-20 week scan should be followed up with a scan in the third trimester for placental location. If the woman has had a prior C-section or the placenta previa is central, documentation should be submitted for medical review.
   - If the fetus is not growing, it may represent IUGR (intrauterine growth restriction). Repeat ultrasound may be recommended once per month in the third trimester. More frequent ultrasounds require physician review.

**Limitations:**
1. Ultrasound scans completed in the office are limited to normal scans. If a repeat scan is medically necessary, the patient should be referred to a perinatal center for the ultrasound.
2. Patients with an incompetent cervix must be referred to a perinatal center for a transvaginal scan.
3. Abdominal scans do not diagnose an incompetent cervix and are non covered.
4. Ultrasounds completed for the purpose of obtaining a picture of the fetus or sex determination are not covered.
5. When a limited ultrasound 76815 and followup or repeat ultrasound 76816 are billed on the same date, the repeat ultrasound will be denied. Documentation supporting medical necessity will be reviewed on appeal.

**Note:** Computer Programming for prior authorizations for ultrasounds in pregnancy has still not been completed. However, the ultrasound procedure is subject to post payment review based on this policy.

**Criteria #42: Varicose Vein Surgery**

In the past varicose vein surgery has been accomplished by vein ligation and stripping and/or sclerotherapy. Since this procedure may be accomplished outside of medical necessity, for cosmetic reasons, it has become important to specify coverage indications for the procedure. Codes which may be involved include 37700, 37720, 37730, 37760, 37780, and 37785.

**Coverage medical record documentation must include all of the following:**
1. History and physical documentation must support substantial pain and edema which impair mobility and impact ADL, significant superficial thrombophlebitis, dependent edema, or complications such as venous stasis with ulceration or dermatititis.
2. Abnormal duplex scan.
3. A six month trial of supportive therapy including walking, avoidance of prolonged standing, support or compression hose therapy, leg elevation, and weight reduction when appropriate.
4. Sclerotherapy must be used in conjunction with surgical stripping and ligation. The varicosities must be symptomatic with pain, burning, etc. There must not code may only be provided by the physician or osteopath. Procedures may not be completed by ancillary person be any sapheno femoral insufficiency or disease which occludes deep veins. The veins are bulging above the surface of the skin and are at least 5 millimeters in size.
5. Treatment of spider veins may be covered only when there is medical record documentation of recurrent hemorrhage.

**Non-coverage**
1. Duplex scanning or an ultrasound procedure performed for the purpose of guidance during the injection of sclerosing solution for the treatment of varicose veins is not considered medically necessary. Therefore, ultrasound guided

sclerotherapy is not a covered service.
2. The injection of sclerosing solution into telangiectasis, such as spider veins, hemangiomata, and angiomata is a non-covered service. Treatment for these superficial veins is most commonly provided for cosmetic purposes. Therefore, sclerotherapy or laser treatment of superficial telangiectasis, is not a covered service.
3. Laser ablation and radiofrequency ablation of the saphenous vein are considered investigational alternatives to vein ligation and stripping. Investigational procedures are non-covered services.

**ICD9 Codes supporting medical necessity**
454.0 Varicose veins of lower extremities with ulcer
454.1 Varicose veins of lower extremities with inflammation
454.2 Varicose veins of lower extremities with ulcer and inflammation

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**03- 100 Medical and Surgical Procedures List and Hospital Surgical Procedures**

Lists have been updated to include procedures 21195, 21196, 61885. ☐

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**03- 101 Physician Manual, SECTION 2, Addendum**

**Under Supplies and Equipment (SECTION 2, page 14)**

28.
a.
2. Supplies opened January 1, 2003 for physician office use in conjunction with office treatment have been closed effective October 1, 2003, this includes all codes listed in the section (A4460 through A6231 and L1620 through L3908).

**Limitations (SECTION 2, page 26)**

C.
5. Medical and Surgical Procedures identified by CPT code may only be provided by the physician or osteopath. Procedures may not be completed by ancillary personnel including nurse practitioners and physician assistants, unless a specific exception for a specific code is described as Medicaid policy in this manual.

**Under specific noncovered services 2. (SECTION 2, page 44)**

t. The code 95920–Intraoperative Neurophysiological testing by definition requires monitoring per hour of surgery. As per Medicare guidelines, the procedure is not covered for the surgeon, assistant surgeon, or anesthesiologist. The service is covered only when a separate physician provides the monitoring.

Numbering of the section t. Standby or monitoring by anesthesia was changed to “u” and u.. Treatment and evaluation of subluxation was changed to “v”. ☐

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**03- 102 Hospitals**

Medicaid requirement for UB-92 Form Locator 55 “Estimated Amount Due” including “Due From Patient” has been changed from ‘not required’ to ‘required’.

**Paper: - UB-92**

 Third party pays for the service, report the payment amount in form locator 54 Prior Payments and the estimated amount due including “due from the patient” in form locator 55.
It is not necessary to complete the Insurance Payment Report Claim Attachment form (IPR) or to send an Explanation of Benefit (EOB).

 Third party pays $0 or denies the service, Medicaid requires the completion of an Insurance Payment Report Claim Attachment form. Claims submitted without the IPR Form will be returned.

The Insurance Payment Report Claim Attachment form is available at http://health.utah.gov/medicaid/ipr.pdf

**Electronic:**
 Complete the other payer payment information including payer paid amount, patient liability and reason codes.

**Provider Manuals Modified**
SECTION 2 of the Utah Medicaid Hospital Provider Manual is updated.

SECTION 2 page 27 of 28

SECTION 2, GENERAL INFORMATION,
Chapter 5 - 1, Inpatient Hospital Claims with Third Party Insurance, page number 27 of 28.
Utah Medicaid Provider Manual for Hospital Services, SECTION 2, Chapter 5-1,Inpatient Hospital Claims with Third Party Insurance, page 27. There is a link to the current version of SECTION 1 on the Medicaid Provider's web site: http://health.utah.gov/medicaid A vertical line marks where text was changed. A reminder of this change in billing procedures for Inpatient Hospital Claims with Third party Insurance under the section for Inpatient Hospital Claims with Third party Insurance will be posted on the Medicaid Provider's WHAT'S NEW site: http://health.utah.gov/medicaid/provhtml/what_s_new.html ☐

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**03- 103 Inpatient Hospital Claims with Third Party Insurance**

SECTION 1, GENERAL INFORMATION, Chapter 11 - 4, Billing Third Parties, states the general policy in regard to patients who have liable third parties such as private insurance, a health maintenance organization, Medicare Part A and B or B only, or Qualified Medicare Benefits (QMB), in addition to Medicaid. However, when a patient with third party insurance receives inpatient hospital services, there are two clarifications to the general information:

1. If the third party pays on the claim, submit the claim to Medicaid and show the TPL amount and the due from patient amount.

2. Payment is limited to patient liability. However, if the adjusted DRG amount from the TPL is less than the patient liability, the adjusted DRG amount is paid. Likewise, Medicare cross-over claims are paid by Medicaid according to the lower of the DRG amount less amounts paid by Medicare and other payers, or the Medicare patient liability - co-insurance and/or deductible. ☐

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**03- 104 Medicaid Publication or Form Request**

This form has been updated. For best service, please use the August 2003 version of this form. It is available on the Medicaid web site at http://health.utah.gov/medicaid/pdfs/requestform.pdf ☐

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**03- 105 Attention Hospitals: Payment Rules for Post-Stabilization Services**

One of the new requirements in the Federal Medicaid Managed Care Final Rule dictates when managed care plans (Plan) must reimburse hospitals for post-stabilization services and when the hospital is financially responsible.

Medicaid currently contracts with Plans to provide physical health care and Prepaid Mental Health Plans to provide mental health care. For physical health care, Medicaid contracts with Healthy U, IHC Access, and Molina. For mental health care, Medicaid contracts with nine Prepaid Mental Health Plans (Bear River Mental Health, Central Utah Counseling Center, Davis Behavioral Health, Four Corners Community Behavioral Health, Northeastern Counseling Center, Southwest Center, Valley Mental Health, Wasatch Mental Health and Weber Human Services).

Medicaid clients enrolled in a Plan have the name of the Plan printed on their Medicaid card.

**Medicaid clients enrolled in IHC Access:** Please note that the Medicaid fee-for-service system reimburses hospitals for services provided to IHC Access members; therefore, the Medicaid agency follows its fee-for-service payment procedures.

**The following explanation will help you understand the new post-stabilization coverage and payment policy for Medicaid clients enrolled in a Prepaid Mental Health Plan, Healthy U, or Molina.**

**Post-stabilization services** means Medicaid services related to an emergency medical condition that are provided after a Plan member is stabilized in order to maintain the stabilized condition, or improve or resolve the Plan member's condition.

In general, post-stabilization services begin when a Plan member is admitted for an inpatient hospital stay after emergency services to evaluate or stabilize the emergency medical condition have been provided in the emergency department. However, in situations where the hospital demonstrates the Plan member received emergency services related to an emergency medical condition during the inpatient admission, the Plan will reimburse the hospital in accordance with federal regulations governing emergency services.

**Emergency services** means covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition. The Plans must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the Plan.

For Medicaid Plan members, **emergency medical condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

**The scenarios below describe when the Plan versus the hospital is financially responsible for post-stabilization services. In each instance, the Plan member first received emergency services for an emergency medical condition after which he or she was stabilized.**

**The Plan is financially responsible for all or part of the post-stabilization services when:**

-- The Plan provider or representative has pre-approved the post-stabilization services.

-- The Plan has not pre-approved the post-stabilization services, but the hospital contacted the Plan for approval of post-stabilization services. The Plan is responsible to pay for at least one hour after the hospital requests approval. For example, the hospital admits the Plan member at noon, but does not contact the Plan until 4:00 p.m. to request approval. In this case, the Plan is responsible to pay the hospital for the first hour after the hospital requests approval (4:00 p.m. to 5:00 p.m.) whether or not the Plan approves further post-stabilization services. Therefore, it is important that hospitals contact the member's Plan for approval of post-stabilization services **prior to or upon admission** to a medical or psychiatric unit.

-- The Plan approves further post-stabilization services beyond the first hour. The Plan is responsible to pay from the time the hospital contacts the Plan and the Plan approves the services; i.e., starting at 4:00 p.m.

-- The hospital cannot contact the Plan and has documentation verifying attempts to contact the Plan. The Plan is responsible from the time the hospital attempted contact.

-- The Plan does not respond to the hospital's request for approval. The Plan is responsible from the time the hospital made the request.

**The Plan is also financially responsible if:**

– the Plan is contacted, but the Plan representative and the treating physician cannot reach an agreement concerning the Plan member's care, and a Plan physician is not available for consultation.

**The Plan remains financially responsible until:**

– a Plan physician is reached;

-- a Plan physician with privileges at the treating hospital assumes responsibility for the Plan member's care;

– a Plan representative and the treating physician reach an agreement concerning the Plan member's care; or

-- the Plan member is discharged.

**The hospital is financially responsible for post-stabilization services up to the point when the hospital contacts the Plan for approval. The hospital is also financially responsible when a Plan physician and hospital's treating physician disagree about the Plan member's care; i.e., the Plan does not approve the post-stabilization services, but the hospital continues to treat the member.**

The specific federal regulations related to post-stabilization care services are in 42 CFR 422.113(c).

If you have questions about this MIB, please call:

Questions regarding physical health plans:
Barbara Christensen
(801) 538-6456
Email: Bbchristensen@utah.gov

Questions regarding Prepaid Mental Health Plans:
Karen Ford
(801) 538-6637
Email: Kford@utah.gov ☐

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**03- 106 CHEC: HIPAA Related Code Changes**

Effective October 1, 2003, the billing procedure code Y0888 for blood lead specimen collection, and the billing modifier code "CF" (CHEC follow-up) have been discontinued and have been replaced with HIPAA approved codes/modifiers. The Child Health Evaluation and Care Medicaid Provider Manual SECTION 2 has been revised as follows to reflect these changes:

1. In SECTION 2, Chapter 2 - 5, item 5. F (Page10) *Codes for blood lead level test,* we have deleted the instruction beginning with "CHEC providers may...." and ending with "children up to age 2". The instruction now reads: "***CHEC providers may use CPT code 36415 when submitting claims for blood lead specimen collection for children up to age 2. When billing for blood lead specimen collection for children ages 2 and older, CHEC providers may use CPT code 36415 with the modifier HA."***

2. In SECTION 2, Chapter 4 - 2 (Page15), in the paragraph beginning with "Medicaid must track...", we have deleted the bolded text which read "enter CF.....in the modifier field", and replaced that bolded text with the new instruction to "***enter 'EP' (a HIPAA approved modifier for EPSDT programs) in the modifier field...".***

   If you have questions regarding these changes, please contact Marilyn Haynes-Brokopp at (801) 538-6206. ☐

**This bulletin is available in editions for people with disabilities. Call Medicaid Information:**
**538-6155 or toll free 1-800-662-9651**

## NEW On-Line (Internet) Address for Medicaid

The On-Line (Internet) address for Medicaid has changed to:
**http://health.utah.gov/medicaid**

If you have a problem finding a Medicaid web page, or Medicaid document on the Internet, it is probably because your browser cannot find the old web site. So start on the new home page: http://health.utah.gov/medicaid, find the page you want, and make a new bookmark on the page with the correct address, or correct the Internet address for your old bookmark.

Your old bookmarks may work for a while. But you really need to fix the Medicaid bookmarks to be sure you are getting the latest information. The old Medicaid Internet address is printed in many Medicaid documents. The old address will be corrected when the document is updated. We apologize for any frustration or confusion this change in address has caused.

## Separate Bulletins Issued for Non-Traditional Medicaid Plan and Primary Care Network

The Division of Health Care Financing issues separate bulletins to inform providers of changes in the Non-Traditional Medicaid Plan and the Primary Care Network Program. The bulletins are mailed only to enrolled providers who are affected by information in the bulletins.

All bulletins are available on the Medicaid Provider's web site: http://health.utah.gov/medicaid/html/provider.html

Bulletins are under the headings Medicaid Information Bulletins, Non-Traditional Medicaid Plan, and Primary Care Plan. Contact Medicaid Information if you want a printed NTM or PCN bulletin that is not included with this Medicaid bulletin.